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Open Forum

Cognitive-Behavioral Couple's Treatment for Posttraumatic Stress Disorder

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Cognitive-behavioral theory and technique has been relatively underutilized in treating individuals with posttraumatic stress disorder (PTSD) within a couple's therapy context. This is despite the clinically recognized and empirically established association between PTSD and intimate relationship problems (e.g., Beckham, Lytle, & Feldman, 1996; Byrne & Riggs, 1996; Carroll, Rueger, Foy, & Donahoe, 1985; Jordan et al., 1992). Although existing cognitive-behavioral treatments for PTSD are extremely beneficial for some clients (Rothbaum, Meadows, Resick, & Foy, 2000, for review), there are limitations to these existing treatments, including problems in delivery (i.e., attrition rates as high as 50% in some samples) and outcomes (e.g., variable success in treating avoidance/numbing symptoms; 25% to 60% still meet diagnostic criteria for PTSD at the end of treatment and at follow-up periods; see Zayfert, Becker, & Gillock, 2002, for discussion). Moreover, these treatments have not been specifically designed to address the complex interplay of intimate relationships and PTSD. In an effort to extend our treatment repertoire for PTSD, we developed a Cognitive-Behavioral Couple's Treatment (CBCT) for PTSD that addresses cognitive and behavioral mechanisms thought to contribute to both PTSD and intimate relationship discord. This article provides an overview of the treatment protocol.

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This approach evolved out of our work with veterans suffering from military-related PTSD—primarily men suffering from combat-related trauma—within the Family IMPACT (Family Integration in the Management, Prevention, Assessment, and Counseling of Trauma) Project at the White River Junction VA Regional Office and Medical Center, Mental Health/Behavioral Science Service and National Center for PTSD, Executive Division. However, the interpersonal problems of men and women suffering from PTSD caused by the exposure to a wide variety of stressors appear to be remarkably similar to those suffering from combat-related trauma (e.g., Herman, 1992; Neumann, Houskamp, Pollock, & Briere, 1996). In brief, individuals with PTSD report greater frequency and severity of intimate relationship dysfunction, including intimate aggression. PTSD is also associated with a higher rate of separations and divorce. The avoidance/numbing cluster of PTSD has been implicated in relationship discord and intimacy problems, and there is some evidence of an association between hyperarousal symptoms and the perpetration of physical and psychological aggression in male veterans. Most of the empirical research that has been conducted with the significant others of traumatized individuals has consisted of female partners of male combat veterans. These partners report a wide range of mental health and relationship problems that have been found to be associated with their partner's PTSD symptomatology. Despite the similarity of these relationship issues caused by various forms of trauma, there are also symptoms unique to specific types of trauma.

Previous Studies of Conjoint Therapy for PTSD

The identification of intimate relationship problems associated with PTSD and discussion of the role of traumatized individuals' partners in trauma treatment (e.g., Byrne & Riggs, 1996; Carroll et al., 1985; Erickson, 1989; Figley, 1988, 1989; Johnson, Feldman, & Lubin, 1995; Johnson & Williams-Keeler, 1998; Matsakis, 1994; Riggs, 2000; Riggs, Byrne, Weathers, & Litz, 1998; Tarrier, Sommerfield, & Pilgrim, 1999) has not necessarily translated into treatment research efforts. To our knowledge, there have been only two controlled and two uncontrolled studies that have investigated conjoint treatment for PTSD. Treatments employed in these studies consisted of generic forms of behavioral couple's/family therapy (i.e., no specific focus on PTSD-related issues).

Randomized Clinical Trials

In a dissertation study of group behavioral couple's therapy compared to wait list, Sweany (1987) found a significant decrease in self-reported PTSD symptoms for those in treatment compared to the control condition. Furthermore, there were trends for improvements in relationship satisfaction and the veteran's depression. Also using a veteran sample, Glynn et al. (1999) compared individual exposure therapy alone to individual exposure therapy followed by behavioral family therapy (BFT; 89% were conjugal partners) to a wait-list control group. They found significant improvements in the positive symptoms of PTSD (i.e., reexperiencing and hyperarousal) for both active treatments compared to the control group, but no differences between the two active treatments. There were no significant improvements found in the negative symptoms of PTSD (i.e., avoidance

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and numbing) across the three conditions. It should be noted that there was a high dropout rate in the BFT condition (i.e., 35%), which the authors attributed to the delay prior to receiving BFT and the fragility of these veterans' relationships. Experiences with exposure therapy may also explain this attrition, given the study's sequential design.

Uncontrolled Trials

Two uncontrolled treatment studies of conjoint therapy have been reported. Using group behavioral couple's therapy with combat veterans, Cahoon (1984) found statistically significant improvements in PTSD symptoms and coping ability (as rated by the group leaders; effect sizes .47 and .72, respectively). While the veterans reported nonsignificant improvements in emotional and problem-solving communication (effect sizes .18 and .41, respectively), the veterans' female significant others reported significant improvements in marital distress and problem-solving communication (effect sizes .34 and .56, respectively). Rabin and Nardi (1991) also provided a cognitive-behavioral group couple's treatment with Israeli combat veterans and their wives, which included psychoeducation about PTSD. Minimal objective outcome data are provided from this study; however, 68% of the traumatized men and their wives reported relationship improvements. However, this study did not show a decrease in the veterans' PTSD symptoms.

CBCT for PTSD

CBCT[1] has received widespread validation for treatment of couple's distress and dysfunction (see Christensen & Heavey, 1999, for review), and has been extended and empirically tested in the treatment of individuals suffering from a variety of clinical problems. With regard to depression, domestic violence, alcohol and drug dependence/abuse, and agoraphobia, CBCT has been found to be equally or more efficacious than individual or group therapy in treating the primary clinical problem. Moreover, CBCT has a variety of additional benefits, including increased relationship satisfaction, decreased intimate aggression, less time separated, fewer divorces, more efficient treatment (i.e., greater gains, quicker), less attrition from treatment, and treatment-related cost savings (e.g., Arrindell & Emmelkamp, 1986; Daiuto, Baucom, Epstein, & Dutton, 1998, for meta-analysis regarding agoraphobia; Fals-Stewart, Birchler, & O'Farrell, 1996; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; McCrady, Stout, Noel, Abrams, & Nelson, 1991; O'Farrell et al., 1996; O'Leary & Beach, 1990; O'Leary, Heyman, & Neidig, 1999).

Taking into account the devastating and largely untreated relationship problems associated with PTSD, some preliminary evidence supporting the efficacy of behavioral couple's therapy for PTSD, and the established efficacy of CBCT for a variety of other individual problems, we have developed a cognitive-behavioral couple's treatment specific to PTSD. The treatment is grounded in cognitive-behavioral conceptualizations of intimate relationship discord and PTSD.

Cognitive and Behavioral Mechanisms

Behavioral conceptualizations have been offered to explain intimate relationship discord and PTSD, respectively. In the case of intimate relationship discord, nonreinforcing, conflictual, and/or abusive behavior and communication are considered to cause and maintain couple distress and are primary targets for intervention (Jacobson & Margolin, 1979). Mowrer's (1960) two-factor explanation of conditioned fears has been used to explain the development and maintenance of PTSD symptoms (e.g., Foa & Kozak, 1991; Keane, Zimering, & Caddell, 1985). Classical conditioning processes are postulated to explain the origins of the anxiety response, while operant conditioning processes explain its maintenance (i.e., negative reinforcement of fear through behavioral avoidance). Experiential avoidance, or avoidance of private experiences (e.g., feelings, memories, behavioral predispositions, thoughts; Hayes & Gifford, 1997, for review) construed to be negative, is a particular form of avoidance that has recently been implicated in the development and maintenance of PTSD (Boeschen, Koss, Figueredo, & Coan, 2001). Behavioral interventions for PTSD are aimed at exposure to traumatic memories and trauma-related cues, with the goal of anxiety habituation. While the trauma exposure may differ with regard to the dimensions of exposure type (i.e., imaginal versus in vivo), exposure length (i.e., short versus long), and arousal level during exposure (low versus high), they share the common feature of having patients confront their fears, and are generically referred to as "exposure" treatments for PTSD (Foa & Rothbaum, 1998).

Cognitive constructs have been incorporated into these behavioral conceptualizations of PTSD and relationship dysfunction. Selective attention to negative events, distress-maintaining attributions, unrealistic and/or unshared expectancies, conflicting assumptions, and differing standards have been found to be associated with intimate relationship discord (Baucom, Epstein, & Rankin, 1995). Similarly, information (Lang, 1977) and emotion (e.g., Foa & Kozak, 1991) processing theories have been used to explain the processes through which traumatic memories and associated affects are stored, maintained, and targeted in treatment. Schemas, or cognitive structures of meaning, have also been used to explain how trauma affects a person's belief system and the adjustments (i.e., schema accommodation and assimilation) necessary to reconcile the traumatic event with existing beliefs and expectations and to process associated emotions (e.g., Resick & Schnicke, 1993). Cognitive interventions consist of challenging irrational and/or dysfunctional thoughts and beliefs related to intimate relationship discord or PTSD.

Interplay of intimate relationship discord and PTSD. Similar cognitive and behavioral mechanisms are postulated to underlie PTSD and relationship discord, and can interact to maintain or exacerbate both problem areas. If successfully targeted in treatment, this reciprocal association holds potential to ameliorate both PTSD and intimate relationship dysfunction.

In CBCT for PTSD, avoidance is considered to be a primary behavioral mechanism contributing to PTSD and intimate relationship problems, and is consequently targeted early on and throughout treatment. This notion is supported by empirical research that has revealed an association between the avoidance/numbing PTSD symptom cluster and diminished relationship satisfaction and intimacy. In this research, numbing symptoms were especially problematic to relationship functioning (Riggs et al., 1998). Likewise, the avoidance of affective expression and sharing in intimate relationships has long been associated with diminished relationship satisfaction and intimacy in couples in general (see Gottman & Levenson, 1986, for review).

[1]For this review, we use CBCT to describe the treatments to date that have been expanded to treat people suffering from a variety of individual problems. However, CBCT is part of a larger class of conjoint interventions with varying emphases and interventions. These treatments are also referred to in the literature as behavioral couple's therapy, behavioral marital therapy, behavioral conjoint therapy, and integrative behavioral couple therapy.

Monitoring for the various means by which an individual or couple may exhibit avoidance is considered integral to successful treatment. Avoidance may consist of more traditionally considered behavioral avoidance of trauma-related cues and reminders. However, this avoidance may be generalized to include experiential avoidance, as well as avoidance of certain individual or couple's issues. Experiential avoidance is considered to frustrate intimacy because of the diminished ability for affective expression and communication. "Avoiding avoidance" is accomplished through psychoeducation and the couple's development of conflict management and communication skills that can be used to discuss and manage increasingly distressing issues previously avoided. The discussion of these topics, including trauma-related thoughts, feelings, and behaviors, provides opportunities to directly address the issues contributing to PTSD. Moreover, specific emphasis is paid to emotion identification, sharing, and reflection in couple's communication, and the value of emotion expression and tolerance in individual and couple functioning is underscored. Conflict-management skills building is also postulated to improve management of PTSD hyperarousal symptoms such as anger and irritability, which have been found to be associated with intimate aggression perpetration (Savarese, Suvak, King, & King, 2001).

CBCT for PTSD is not considered to be an exposure treatment: Individuals are not confronted with specific traumatic experiences with the goal of anxiety habituation. Rather, consistent with cognitive conceptualizations of PTSD, individuals are encouraged to focus on the various emotions surrounding their memories and reminders of the event(s), as well as the meaning of the event(s) for the here-and-now. Thus, we argue that relaying the specific details is less important than fully experiencing, expressing, and processing the emotions attached to them. In this cognitive vein, similar cognitive structural (i.e., schemas), content (i.e., irrational and/or dysfunctional thoughts, beliefs, standards, assumptions, attributions), and process (i.e., accommodation, assimilation) variables have been used to explain the development and maintenance of intimate relationship discord and PTSD.

McCann and Pearlman's (1990) work, also incorporated into Cognitive Processing Therapy (CPT; Resick & Schnicke, 1993), provides cognitive content relevant to PTSD and intimate relationships that is specifically targeted for cognitive intervention. They outline five areas of functioning frequently affected by traumatic experiences: safety, trust, power/control, esteem, and intimacy. Consistent with CPT, thoughts and beliefs held across these areas are explored and challenged as they relate to the self and other, with the goal of schema accommodation and emotional processing. These themes, including their interpersonal focus, fit nicely with the conjoint therapy frame.

Treatment Format

Routine pre- and posttreatment assessments are highly encouraged, regardless of whether the treatment is delivered in a research protocol or in nonresearch practice. Prior to initiating treatment, we provide clients with feedback about their PTSD symptoms, relationship functioning, and associated psychological issues. This feedback is used as an aid to psychoeducation and in treatment goal setting, and supports the goal-oriented focus of treatment. In our experience, couples have been eager to receive their assessment results, and these results have enhanced treatment delivery. We use both self-report (PTSD Checklist; Weathers, Litz, Herman, Huska, & Keane, 1993) and interview (Clinician-Administered PTSD Scale for *DSM-IV*; Blake et al., 1990) methods for assessing PTSD. Relationship variables assessed include relationship satisfaction (Dyadic Adjustment Scale; Spanier, 1976), intimate aggression (Conflict Tactics Scale–Second Edition; Straus, Hamby, McCoy, & Sugarman, 1996), communication skills (10-minute communication sample about a moderately distressing topic for behavioral coding), and adult attachment (Experiences in Close Relationships; Brennan, Clark, & Shaver, 1998). Depression (Beck Depression Inventory; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961), anxiety (State-Trait Anxiety Inventory; Spielberger & Lushene, 1989), and affective control (Affective Control Scale; Berg, Shapiro, Chambless, Ahrens, 1998) are associated features assessed.

CBCT for PTSD consists of 15 weekly sessions comprising three primary treatment phases: (a) treatment orientation, psychoeducation about PTSD and its related intimate relationship problems, and safety building; (b) communication skills training; and (c) cognitive interventions. Each 75-minute session begins with an overview of what is to be accomplished in the session, and includes didactic information to convey to clients and skills for them to practice in the session. Out-of-session assignments conclude each of the sessions (see Table 1).

The first three sessions of the treatment are focused on orienting the couple to treatment, psychoeducation about PTSD, relationships and avoidance, and establishing safety within the couple and the therapeutic relationship. The first session outlines treatment expectations and presents the phase-oriented, here-and-now, goal-oriented, and time-limited nature of the treatment. We candidly discuss the issue of trauma disclosure and solicit possible concerns, desires, and prohibitions from each member of the couple about this issue (see Special Considerations section for more discussion). The expectation and rationale for out-of-session assignments (we are careful to use the word "assignment" as opposed to "homework" based on feedback from our clients) are also provided in this session. Treatment goals are mutually developed, and each member of the couple signs a treatment contract containing these goals and the above treatment expectations. Session 1 also emphasizes the importance of increasing positive couple behavior while decreasing negative couple behavior. This leads to the first out-of-session assignment: daily attention to their partner's positive behavior.

Session 2 is devoted to understanding PTSD as an anxiety disorder as well as introducing a cognitive-behavioral conceptualization of PTSD. Couples receive information about hallmark PTSD symptoms and associated problems, for example, the maintenance of PTSD through avoidance strategies such as experiential avoidance. We also explore the hypothesized deleterious role of experiential avoidance in intimate relationships (i.e., avoidance and/or numbing symptoms) and its manifestation in the specific couple's relationship. The notion of habituation is presented to provide a rationale to support the couple in discussing uncomfortable and distressing topics. The third session is spent exploring the existence of very negative behavior (e.g., intimate aggression, threats to leave the relationship, ongoing infidelity), and developing conflict-management skills (e.g., timeouts).

Communication skills training. Sessions 4 through 8 focus on traditional communication skills building (e.g., listening/paraphrasing; assertiveness, emotional versus problem-solving communication; emotion identification, sharing, and reflection) using increasingly distressing topics (low to moderate range) based on the couple's current difficulties. In the fourth session, the couple

views their pretreatment communication sample with the therapist. This supports the rationale for communication skills training and allows the couple to observe their communication from a more objective perspective. The couple is asked to audiotape 5 to 10 minutes of communication each week in their home setting during this treatment phase, utilizing the communication skills they are building. These audiotapes are reviewed with the couple in the next session to troubleshoot and to provide positive feedback to the couple.

Cognitive interventions. In the final phase of treatment, the couple more deeply consolidates their knowledge about PTSD and intimate relationships using their newly developed skills to address the effect of trauma on themselves and their relationship. Session 9 introduces the influence of trauma on how people perceive the world, themselves, and others, and the role of dysfunctional thoughts and beliefs in maintaining distress. The five themes outlined by McCann and Pearlman (1990) presented above (i.e., safety, trust, power/control, intimacy, and esteem) are introduced over five sessions and used as communication topics for the couple's out-of-session practice. The couple is encouraged to draw upon their communication skills and to assume a posture of curiosity as they nonjudgmentally explore and gently mutually challenge or support their thoughts and beliefs held in these areas. Each session concludes with an out-of-session assignment to discuss the identified area presented in that session over the subsequent week, audiotaping at least one of the communications for review at the next session.

The final session is spent reviewing and reinforcing gains made in therapy and anticipating future challenges.

Special Considerations

We recently completed an open trial of CBCT for PTSD to fine-tune the treatment manual (available from the first author), train therapists, and provide initial evidence regarding its safety, tolerability, and efficacy. From this initial, and other's, work, we offer up the following considerations.

Dually Traumatized Couples

Dually traumatized couples may be more the rule than the exception. This is especially likely when working with couples wherein the initially referred patient has a female partner because of the two-to-one prevalence of PTSD in women versus men (e.g., Kessler, Sonnega, Bromet, Hughs, & Nelson, 1995). In addition, previous research suggests that people who have a psychological disorder are more likely to marry or cohabit with people who also have a psychological disorder (Du Fort, Kovess, & Boivin, 1994). The partner may have experienced primary traumatization prior to or during their intimate relationship as a result of family-of-origin violence, exposure to domestic violence perpetrated by their partner with PTSD or previous partner, sexual assault, or some other type of trauma. In addition, a number of authors have discussed vicarious or secondary traumatization of these partners as a result of strong emotional connections with the trauma victim (e.g., Figley, 1989; Nelson & Wright, 1996; Rosenheck & Nathan, 1985). Thus, we assume, and it has been the case thus far in our work, that partners are likely to present with PTSD and/or some other type of psychological problem.

The treatment principles and interventions of CBCT for PTSD are considered to be sufficiently broad and flexible to meet the challenges of couples with their respective psychopathology. Evidence to support this assertion is that all of the female partners in our study had trauma histories and/or clinical levels of depression, anxiety, and/or PTSD symptoms. Therapists should anticipate possible reactions to disclosures and distressing topics, monitor for any changes in risk factors (e.g., suicidality, aggression, substance abuse) for both members of the couple, and stress the importance of emotional and physical safety throughout therapy.

Trauma Disclosure

Another important point to highlight about the treatment is that we explicitly discuss with the couple that there is no requirement that either of them disclose specific information about their trauma history. In general, we encourage clients to talk about their trauma histories as they relate to here-and-now thoughts and feelings; we discourage in-depth, gory, and/or gratuitous retellings of their experiences. We have adopted this approach to avoid possible vicarious traumatization of partners and based on clinical trials supporting the efficacy of cognitively focused approaches to PTSD treatment (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Resick, Nishith, Weaver, Astin, & Feuer, in press; Tarrier et al., 1999). Even if clients do not share details of their traumatic experiences, beliefs and emotions linked to their traumas are likely to be evoked, which provides opportunities for habituation, schema accommodation, emotional processing, and greater mastery and tolerance of these emotions.

Type of Trauma

As noted in the introduction, military-related trauma is clearly not the only form of trauma exposure that leads to significant interpersonal difficulties. By their very nature, interpersonal traumas appear likely to lead to intimate relationship problems and may be particularly well suited for CBCT. For example, Follette and Pistorello (1995) outlined various problems found in couples in which the woman was a victim of childhood sexual assault; they also suggest the use of interventions to address experiential avoidance. Some specific problems related to sexual assault/abuse may include retriggering of traumatic memories and sensations, dissociation, or flashbacks during the couple's sexual relations; hyper- or hyposexuality; problems with libido; or general negative attitudes about sex. Revictimization is clearly of concern with victims of interpersonal violence (e.g., Messman-Moore & Long, 2000) and is an issue that should be specifically assessed and addressed within the conjoint context (i.e., history of, or current emotional, physical, or sexual abuse within the relationship).

Summary

Our challenge in advancing PTSD treatment is to offer innovative stand-alone or adjunctive treatments for those individuals who have not responded or fully benefited from available empirically validated treatments. Given the established interpersonal costs of PTSD and proven efficacy of conjoint therapy for other individual problems, we believe that CBCT for PTSD holds promise as an efficient and efficacious treatment for individuals and their loved ones with PTSD.

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Table 1
CBCT for PTSD Session Overview

Pretreatment Session: Treatment Summary and Informed Consent Procedures
Pretreatment Session: Self-Report, CAPS, and Behavioral Assessments
Pretreatment Session: Review of Assessment Results

Session 1	Introduction of Treatment Model, Frame, and Contract	
	Out-of-session assignment:	session overview
		treatment contract
		common reactions to trauma
		Catch Your Partner Doing Something Nice I
		impact statements
Session 2	Psychoeducation About PTSD, Relationships, and Avoidance	
	Out-of-session assignment:	PTSD and avoidance handout
		Catch Your Partner Doing Something Nice II
Session 3	Safety Building	
	Out-of-session assignment:	steps to an effective time-out
Session 4	Introduction of Communication Skills Training	
	Out-of-session assignment:	common communication problems handout
		Dirty Fighter's Instruction Manual handout
Session 5	Listening and Paraphrasing	
	Out-of-session assignment:	communication practice-listening/paraphrasing
		communication reviews
Session 6	Assertive Speaking	
	Out-of-session assignment:	assertiveness definitions and barriers
		assertivness table
		making assertive requests and refusals
		communication practice-assertive speaking
		communication reviews
Session 7	Communication Channels	
	Out-of-session assignment:	communication channels hand-out
		communication practice-communication channels
		communication reviews
Session 8	Identification, Sharing, and Reflection of Feelings	
	Out-of-session assignment:	Feeling Faces handout
		daily expression and reflection of feelings
		communication practice-feelings
		communication reviews
		treatment contract review
Session 9	Cognitive Overview*	
	Out-of-session assignment:	stuck-points handout
		problematic-thinking handout
		thinking about trauma and relationships handout
		safety-issues handout
Session 10	Safety Issues	
	Out-of-session assignment:	communication practice-safety
		communication reviews
		trust issues handout
Session 11	Trust Issues	
	Out-of-session assignment:	communication practice: trust
		communication reviews
		power and control issues handout
Session 12	Power and Control Issues	
	Out-of-session assignment:	communication practice-power and control
		communication reviews
		intimacy issues handout
Session 13	Intimacy Issues	
	Out-of-session assignment:	communication practice-intimacy
		communication reviews
		esteem issues handout
		A Compliment a Day
Session 14	Esteem Issues	
	Out-of-session assignment:	communication practice-esteem
		communication reviews
		impact statements ii
		review of treatment gains
Session 15	Review and Reinforcement of Gains	

Posttreatment Sessions: Self-report, CAPS, and Behavioral Assessments
*Midtreatment Assessment - PTSD Checklist and Dyadic Adjustment Scale